

<b>MEDICAL CERTIFICATION FORM</b>	
Employee Name:	Date:
Unit:	
Job Title:	
Telephone Number:	SS#
<b>The following information is needed to assess the employee's request under the Americans with Disabilities Act.</b>	
Type of Prognosis: (Please explain in detail)	
Is this Condition: _____ Temporary _____ Permanent	
Date the Condition Began:	Date Return to Work:
Does this condition allow the employee to perform the Essential Functions of this job? ____ YES ____ NO	
If not, please describe what type of accommodation is needed for which essential function.	
Other Comments:	
Employee's Signature:	Date:
Supervisor's Signature:	Date:
Health Care Provider's Signature:	Date:
Health Care Provider's Printed Name, Address and Telephone Number:	

**Youth Services**  
**Attn: ADA Coordinator**  
**P. O. Box 66458**  
**Baton Rouge, LA 70896**